SERVICE DELIVERY IMPROVEMENT DIVISION

STRATEGY ISSUES PAPER

DECEMBER 19, 2002

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Service Delivery Improvement Division
Strategy Issues Paper

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SDI Strategy Issues Paper
Executive Summary

Background: The purpose of this strategy issues paper is to document for the Service Delivery Improvement (SDI) Division a set of strategic issues and directions to consider for shaping its work in the future in the area of family planning and reproductive health (FP/RH) service delivery. The paper outlines key areas identified by USAID staff and stakeholders as important for the future of FP/RH service delivery, as well as the current environment and USAID programmatic issues for FP/RH at the field level. Suggestions are made for how the Division positions its resources, both human and financial, to support the Office's strategic objective as well as the related goal of the Agency.

Where are we today? USAID has been an integral part of a revolution that has seen millions of couples benefit from FP/RH services. Yet the need for family planning services will continue to increase rapidly in the next decade. Growth rates are slowing but global population will not level off until it has reached 11 billion in the last half of this century. There are still millions of couples, particularly the poor, who have not been reached and continue lives where their full potential is compromised. At present there are approximately 488 million family planning users but numbers will increase dramatically in the next decade. Most population growth in the developing world will take place in urban areas, especially in secondary cities, although currently roughly 60% of the world's population is still rural. HIV/AIDS has emerged as an international crisis and an urgent priority for the countries with highest prevalence rates. FP/RH services in some countries are not being given much priority as human and financial resources are increasingly dealing with HIV/AIDS. Many countries are also undergoing health sector reform, which is often accompanied by profound changes in the way FP/RH and other health services are organized and financed. Conflict and social upheaval are also common in many parts of the world. Donor funding, however, for FP/RH programs is declining and that decline is likely to continue. Clearly new strategies are needed to ensure that the growing needs are met in affordable and sustainable ways. Many are looking to USAID for the necessary leadership.

Where does SDI need to be? The mandate of the Bureau for Global Health (GH) is to support the field, provide global technical leadership, and undertake research on behalf of the Agency. SDI's mandate is to support field missions with the full range of technical services necessary to improve the delivery of family planning and reproductive health services. These include programmatic areas that USAID has been working in for years including scaling up private and public services and supplies, increasing access to quality services, improving the method mix and informed choice, ensuring appropriately skilled providers, assuring a steady supply of contraceptives and essential drugs and ensuring the sustainability of programs. The results of technical and programmatic innovation must be effectively mainstreamed and scaled up in country programs. In order to serve the field appropriately, SDI must design FP/RH programs that are flexible, respond to a variety of different needs, and provide the technical depth and specialization in certain topics that field missions need to enhance their programs. Central mechanisms must also provide optimal support to field staff. In keeping with the Administrator's policy to shift more

responsibility and resources to the field, Missions with bilateral population projects must have Agency resources to support their efforts. SDI needs to improve ways of providing technical support to bilateral programs as well as finding appropriate mechanisms to program field support funds. While not a problem unique to SDI, the Division is having difficulty managing large projects, making judicious use of core resources, and, at the same time, providing timely strategic and technical support to field missions. Competing priorities are diluting the opportunity to have a major impact.

What are SDI's strategic priorities? As result of reviewing strategic options, the Division sees the following priorities for use of SDI's core financial resources: (1) advocacy for, and adoption of, best practices for family planning and reproductive health service delivery in collaboration with field missions and with external partners and, (2) application of core resources to complement mission efforts to strengthen institutions and local capacity at the country level. The highest priority for use of SDI human resources is to provide the field missions with the technical expertise and strategic assistance they need to strengthen their FP/RH service delivery programs. At the same time, SDI must manage the current and future portfolio in ways that meet mission needs and provide the support that missions have come to expect from the Bureau. For the most part, the technologies and best practices to strengthen service delivery programs already exist and need to be applied and scaled up.

Focusing resources on fewer countries to achieve impact is an important objective. A potential model of categorizing countries into three groups: pre-transition countries, transition countries and low fertility countries, was thought to be useful in terms of prioritizing the types of assistance they may require rather than as a way of choosing countries with which to work. For instance, in pre-transition countries, SDI's assistance would be for strengthening health systems geared to expanding access and quality of services particularly when utilization rates are very low. In transition countries, increasing method mix and helping find ways to scale up programs might be the focus. In low fertility countries, primary attention could be on policy and issues related to sustaining programs over the long run. Other options for categorizing and prioritizing country work, and for assisting field missions on strategy development, have been vetted. The concept of segmenting the population by wealth quintiles to identify those in greatest need, to appropriately target programs, as well as to identify those who can afford to pay for services or use private and commercial sources, is useful. Another potentially useful model is looking at the "systems" issues that affect service delivery. Given the profound impact of changes in the organization and financing of health services on field programs, field missions may need help in devising strategies to keep focused on outcomes and work constructively to strengthen health systems, both public and private.

Taking advantage of existing mechanisms across the GH Bureau is an important strategy for reducing the number of projects, costs, and the management burden. New initiatives are needed in some areas. (1) Strengthening clinical family planning services is needed to re-invigorate clinical family planning and related services. The primary focus should be clinical family planning services because expertise in this area is not readily available through the existing mechanisms. The new activity does need to be able to address

related clinical services as well including PAC, STI counseling and treatment, maternal health services and HIV/AIDS services where appropriate. (2) A new integrated human capacity development and training program is needed to provide GH and field missions with strategic advice and technical assistance related to human capacity development in all GH technical areas. The human resources constraints related to improving worker performance such as manpower planning, personnel deployment, compensation, accreditation, and pre-service training are critical across all of the PHN areas and should be dealt with more strategically.

Improving support to Missions for strategic planning, performance monitoring, and information management is also needed. To extend SDI's capacity, a stable of technical experts with field experience is needed to assist missions with program development. These experts should maintain working relationships with GH technical counterparts in order to be as connected as possible to the Agency's perspective on a particular topic. The recent increase in SDI staff should also expand its capacity to engage proactively with field programs and to provide the technical backstopping in many areas of service delivery improvement that many missions need and want.

For the most part, the service delivery challenges in the field are applying and scaling up known technologies and best practices rather than creating new ones. Too often the emphasis is on creating new technologies and strategies rather than optimizing the use of exiting ones. There is also fairly universal dissatisfaction with the current procedures for ensuring that the information generated from research and the development of best practices are mainstreamed or scaled up in country programs. As mentioned in Section III, substantial resources are spent on developing and distributing technical information that is not being used effectively because people do not have the information in digestible form at a time when they need it. Thousands of hard copies of documents are distributed in Washington and to field missions and dozens of project websites offer similar information but substantial re-thinking needs to occur about how to make this kind of information practical and useful for field mission staff.

There are several needs that are already well-recognized by the Bureau. (1) The volume of technical reports needs to be reduced and rationalized, (2) the technical information coming from several sources needs to be synthesized and packaged appropriately and (3) a process needs to be established to facilitate the state-of-the-art and best practices information being incorporated into field programs. One step to address the last issue has been taken. PHNI will be developing and managing the internal USAID PHN website to provide (and update) this kind of information for use by field and Washington staff. Substantial re-thinking needs to occur, however, about how to make information on best practices and state-of-the-art available in ways that are practical and useful for field mission staff.

SDI Strategy Issues Paper

I. Introduction

Purpose

The purpose of this paper is to document for the SDI Division in the Population and Reproductive Health Office a set of strategic issues and directions to consider for shaping its work in the future in the area of family planning and reproductive health (FP/RH) service delivery. The paper outlines key areas identified by USAID staff and stakeholders as important for the future of FP/RH service delivery, as well as the working environment and program management issues for FP/RH programs within USAID at the field level. Issues related to defining the mandate of the Service Delivery Improvement (SDI) Division are raised and suggestions made for how the Division positions its resources, both human and financial, to support the Office's strategic objective as well as the related goal of the Agency.

Key Strategic Questions

Making choices about future directions requires the SDI Division to look critically at its mandate for the next ten years. The questions are:

- What are the changes in environment in which FP/RH service delivery operates in the developing world and how can SDI best provide the strategic and technical support that missions need?

- Given the Agency's policy of pushing more staffing and resources to field missions, what is SDI's "value-added" to achieve the Agency's objectives in FP/RH? In what ways should its role change in future years?

- Funding constraints are likely to continue. How can SDI make the most strategic use of its core resources?

- How can the SDI Division support the Global Health Bureau to help "re-position" population to make it a more compelling investment for countries and donors. How can GH exercise more effective global leadership that is so badly needed at this juncture, for which many donors are looking to USAID?

Strategy Development Process

Over the past four months, the SDI Division engaged in a number of preparatory activities for developing this strategy paper. These included:

- extensive consultations with PHN officers from field missions, most recently during the Africa and ANE/E&E State-of-the-Art (SOTA) meetings in June and October respectively, consultations with individual PHN officers over the summer, and focus group sessions with groups (Annex 1),
- a wide range of interviews with various stakeholders including CA partners, foundations, other donors, senior USAID staff, and USAID project managers to collect their views about the future on FP/RH issues (Annex 2),
- a review of the advantages and disadvantages of alternative procurement instruments (both acquisition and assistance) available to the Bureau to meet GH mandates (Annex 3).
- a set of four "Knowledge Sharing Meetings" designed to explore in greater depth some of the more critical technical and strategic issues facing field programs (Annex 4),
- a review of the existing SDI portfolio to determine the areas of overlap and the gaps ("Red Dot" exercise), and an analysis of trends in the use of bilateral vs central projects (Annex 5),
- an analysis by the Policy Project entitled "Trends and Issues Affecting Service Delivery Over the Next Decade" (Annex 6),
- A review of the "Use of Bilateral Mechanisms for PHN Programming in the Field" by Susan Thollaug and Maria Mamlouk (Annex 7), and
- external evaluations of the Engender Health and JHPIEGO projects, both of which are ending in September 2003, and an external evaluation of the MAQ Initiative (Annex 8).

The objective of these preparatory activities, guided by an SDI Strategy Development Team, was to gain a better understanding of the challenges facing FP/RH field programs, particularly because much has changed since the last strategy document prepared ten years ago.[1]

Challenges and Changes in the Environment

The following are some of the important background facts that should be taken into consideration in looking at FP/RH programs for the future:

- The need for family planning services will continue to increase rapidly in the next decade. Growth rates are slowing but the population will not level off until it has reached 11 billion sometime in the last half of this century. Especially in Africa the increases are surprisingly large: where there are 100 women in union now, there will be 115 by 2005 and 133 by 2010. In Asia, the subcontinent countries of India, Pakistan, and Bangladesh will add 36 million women of childbearing age from 2000 to 2005 and another 34 million by 2010. Population momentum will also affect the need for family planning services. How will countries and donors deal with this increasing need for FP/RH services?

[1] Destler, Liberi, Smith, Stover, "Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties", Nov. 1990

- Urbanization is an increasingly important phenomenon through out the developing world. Urban populations will grow from 1.9 billion in 2000 to 3.9 billion in 2030. Most population growth in the developing world will take place in urban areas, especially in secondary cities, except in Africa where most of the growth will occur in rural areas. However, it is important to remember that currently the majority of the world's population is still rural (roughly 60%).

- Fertility declines have been impressive. However, these declines are geographically uneven and tend to be slowest in the least developed countries. Furthermore, there are substantial differences in access to and utilization of FP/RH services among various wealth quintiles within countries with the poorest segments of the population being at a significant disadvantage.

- Contraceptive security is not assured. Programs will need an increasing number of methods to maintain current use and to provide for new acceptors. Insufficient funds are available globally to meet this challenge, unless private sector resources are mobilized to fill the gap. Clearly, more will be required from recipient governments, and hopefully more from donors.

- The private sector will have to play a significant role in FP/RH in the future. Public sector programs have been very important in the past but increasingly clients in developing countries are seeking health care from private providers. USAID, while ahead of many other donors in working with the private sector in FP/RH, needs to focus a great deal more attention in the future on private and commercial sources of contraceptives as well as services.

- HIV/AIDS has emerged as an international priority and an immediate and urgent priority for the countries with highest prevalence rates. Family planning and other reproductive health services in some countries are not being given much priority as both human and financial resources are increasingly directed to dealing with the HIV/AIDS epidemic. In some countries in Sub-Saharan Africa, life expectancy and population growth have been severely affected by the epidemic. Meeting the needs of clients for HIV/AIDS services is, and will continue, to severely tax the available health services and limit the ability of the health services to meet other requirements for services like family planning.

- Many developing countries are undergoing health sector reform. These programs are often accompanied by profound changes in the way FP/RH and other health services are organized and financed. Decentralization has fundamentally changed the way programs are planned and managed. In some countries ministry of health mandates are changing and attempts are being made to include private sector and NGOs in national health programs. These important changes must be taken into consideration for strengthening systems that deliver FP/RH services in the future.

- In the post ICPD period, government policies and national health programs have changed to reflect the need to deal with reproductive health in a more integrated and client-oriented fashion. As FP/RH services have become more integrated, providing high quality services has become more complex than in the old-style vertical programs. Family planning services, in particular, are sometimes eclipsed by a myriad of other services. In service delivery systems that are integrated, front line health workers must have skills in a number of programs areas including management of common childhood illnesses, maternal health, providing immunizations, counseling on nutrition and so on as well as providing family planning services. This fact has implications for human resources and skills development.

- Armed conflict, political instability and the movement of refugee groups often cause women and children to become more vulnerable to violence and abuse. Increasingly, FP/RH services must be offered within an environment of tremendous social and political upheaval. Most often the countries affected by political instability are those in the "pre-transition" demographic stage with high unmet need, high fertility, low contraceptive prevalence and very weak service delivery structures. Social change in many countries linked with globalization presents new opportunities but also dangers. Economic changes can create new job opportunities for women but these changes may also widen the divide between rich and poor. Programs must take these factors into consideration.

- The presence of USAID programs in various countries changes depending on geo political and other factors. As USAID withdraws its support for programs in a particular country, how will family planning gains in contraceptive prevalence be sustained in these environments? How will new acceptors be informed and served?

- Financial resources for FP/RH have not kept up with need. Many external factors as well as internal bureaucratic constraints affect USAID's ability to allocate resources to the countries that need them the most. Furthermore, the Administrator has stated a desire to push more staff and resources to field missions given that USAID's comparative advantage as a donor has traditionally been with its decentralized structure and its technical capacity resident at the country level. If more resources go to the field, presumably fewer remain with central Bureaus. The GH Bureau must establish priorities in terms of both the countries and the activities it supports.

II. Key Areas for Technical Leadership for the Future

Extensive consultations with field missions and CA partners who have been on the front lines of implementing USAID's FP/RH programs have revealed that there are still significant challenges in maintaining the "bread and butter" FP/RH programs as well as dealing with the new challenges. These are described in a paper recently completed by

the Policy Project.[2] The authors identify some things that will not change. For instance, it is unlikely that contraceptive technology will change dramatically and therefore contraceptive choices will remain the same. The pillars of good programs will continue to be increased access to quality service delivery, a focus on informed choice, appropriately skilled providers, and a steady and assured supply of contraceptives and essential drugs. Developing and strengthening sustainable service delivery systems at the country level will continue to be at the core of USAID's programs, although the nature of the inputs from USAID should depend on the level of development and capacity of the host country.

The following are key strategic and technical areas that many stakeholders felt were important for FP/RH service delivery in the future. These were gleaned from the field staff consultations, stakeholder interviews, knowledge sharing meetings, as well as the Policy Project Trends and Issues paper. This is not to suggest that new projects are needed in each of these areas but rather, addressing these issues through existing projects, or new ones where needed, must be considered because they are critical to FP/RH service delivery in the current global environment.

Revitalizing Clinical FP/RH Services within Integrated Programs

A balanced FP/RH program, where all contraceptive methods are available at different program levels, is a critical ingredient to success of family planning in the next decade. Appropriate contraceptive delivery systems, where volunterism and informed choice are assured and quality is uncompromised, have to be developed in some countries and nurtured in those where the services already exist. A balanced program has community-based distribution (CBD) at the community level provided by frontline workers and clinical methods at all clinics, offered by skilled providers. Clinical methods should include sterilization, IUD, injectables and also Norplant where appropriate. Some clinics within national systems should provide PAC, including family planning counseling and services. This full-service approach will require a review of national programs FP/RH delivery systems and provider in-service training to ensure that each element of the balanced program is in place.

The preparatory activities highlighted a key issue facing USAID and its country partners in the coming decade, i.e., revitalizing clinical family planning services. While CBD programs, which are less complex to initiate than clinical services, are making progress in re-supply methods, clinical family planning services have languished. The disturbing worldwide trends demonstrate that clinical method use is flat or declining, while the demand for smaller families is quite large and increasing. Clearly greater attention needs to be given to clinical methods, especially to long-term methods, as well as to continue the on-going and planned efforts in commercial and social marketing of short term methods. Increasing method mix is also an important service delivery issue. The following are some key points made by USAID stakeholders.

[2] Ross, Stover, "Trends and Issues Affecting Service Delivery Over the Next Decade", Policy Project, Oct 2002.

Clinical contraception, offering long-term and permanent protection from unwanted fertility, deserves high priority in the future. IUD and sterilization are excellent methods – safe, convenient and cost-effective- but these have been neglected, and have a poor reputation. As a result these are underutilized. There are many clients who indicate they would like a long-term or permanent method but their need for these services is not being met. Consequently there is still considerable unrealized potential and unmet demand for clinical contraception services. The determinants of demand for family planning services are not always well understood in particular country situations suggesting the need for specific analytic work in this area to devise more effective programming strategies. This is particularly important in countries that are at the transition stage where unmet need is high.

In addition to improving clinical service delivery, demand creation i.e., promoting the image of both sterilization and IUD is important. Programs have to educate potential acceptors on health benefits derived from accepting a long-term clinical method. Provider, program, and facility biases need to be addressed. Systems need to be strengthened to provide effective clinical services and follow up of clients. The policy and legal/regulatory environment must also support the efficient provision of services.

In many country programs there is still problems with contraceptive services and supplies. Restricted method availability is one of the greatest shortfalls of current programs. A number of countries still rely primary on just one method. The lack of access to modern contraceptives is still a major obstacle to their use in many countries. This is a critical quality of care issue. When clients have limited access to a range of choice in methods, the quality of the care they are provided is compromised.

Post Abortion Care (PAC) and postpartum care are two services that fall within clinical FP/RH services. Thirty seven percent of all pregnancies end in spontaneous or induced abortions or still-births.[3] Abortion is one of the most frequently performed medical procedures in the world. Globally, there are an estimated 50 million abortions every year, 20 million of which are classified as unsafe; thus, approximately 38 women undergo an unsafe abortion every minute of the day.[4] There needs to be a concerted effort to expand PAC, and especially to ensure that family planning counseling and service provision are an essential element. Postpartum family planning services should be available at all sites where delivery occurs. There should also be greater efforts to reach women who deliver at home with family planning information and services.

There are several critical issues that USAID must track more effectively. 1) Projects need to continue to develop a more efficient and systematic approach for quantifying achievements to show results of activities and tools over time. 2) Improving the quality of services is a high priority. 3) Worldwide experience in identifying approaches to ensure the sustainability of programs needs to be shared and given increased emphasis.

[3] Cobb, Putney, Rochat, Solo, Buano, Dunlop, and Vandenbroucke, "Global Evaluation of USAID's Post Abortion Care Program, Oct 2001.
[4] IPAS, 2000

4) Sustained improvements in clinical family planning require ongoing and long-term system strengthening efforts.

Family planning services are likely to be faced with several integration challenges. There has always been some integration of family planning and safe motherhood at the clinic level. In the future more emphasis may be needed on developing linkages between family planning and pre-and postnatal care, post abortion services and programs to prevent mother-to-child transmission of HIV. Current evidence shows the significant health benefits of a three to five-year birth spacing interval[5] means that child survival as well as family planning programs must ensure the availability of this birth spacing information and the related services.

Appropriate Investments in Human Capacity Development/Training

Health worker performance improvement is an essential ingredient to enhancing the quality of FP/RH services, and should continue to be a pillar of future USAID programming. Within this context, pre and in-service training are equally important investments in improving clinical and counseling skills and ultimately the quality of care provided. However, done in isolation or without attention to system issues that directly determine the value of training, it can also be a tremendous waste of resources. The Knowledge Sharing meeting on this subject pointed out some important lessons to keep in mind for the design of any follow on training activities.

Training should flow from national guidelines on service delivery. Curricula should be built from these guidelines. In all training programs, the "content is king" so time and attention must be devoted to the development of the most up-to-date and appropriate training materials and training techniques. Pre-service education must be aligned with national policy, service delivery guidelines, and the job requirements graduates are expected to meet. Attention should be focused on strengthening clinical training sites reinforcing linkages between clinical training and service delivery.

Attention must also be directed toward opportunities to work with stakeholders to strengthen graduation requirements, accreditation of pre-service education and clinical practice sites, licensure, deployment of trained graduates and their periodic re-certification. Training initiatives provide opportunities for partnering. USAID does not have to take it all on but can provide the technical expertise while funding is provided by the World Bank, DFID, or other donors.

Presently field missions under-invest in pre-service training in favor of in-service training. Yet, both are important and a more balanced approach to funding these training activities is necessary in the next decade. Future training projects should include all health and family planning areas. As many countries now try to deliver an essential service package (ESP) that incorporates several primary health services, training programs will have to be designed to meet integrated service delivery needs.

[5] "Birth Spacing: Three to Five Saves Lives", DHS Study, Johns Hopkins Population Information Program, Oct 2002

Distance learning and e-learning techniques are new areas that can be incorporated into training programs, if these address a particular need. The technology should not drive the decisions but rather objectives of the training should determine the most appropriate technology. E-learning and distance learning requires excellent training materials and learner support. There is a role for both, however, in situations where learners are unable to attend regular training courses away from their places of work.

The JHPIEGO external evaluation also recommended a continuing need for strengthening pre- and in-service training, including broadening the focus beyond FP/RH given that health workers need more than just FP/RH skills and it may be cost-effective to include other areas. The evaluation suggested orienting PHN officers about the importance and value of pre-service training; continuing core investments in pre-service education, materials development, dissemination and trainer networks; strengthening pre-service education with concurrent development of clinical training sites, and increasing efficiency of in-service training systems.

Maintaining Programmatic Focus within Health Sector Reform Programs

At a Knowledge Sharing meeting on this subject, participants agreed that USAID and its partners cannot afford to be on the sidelines of health reform. USAID has much to offer by way of keeping the reform process focused on improving sustainable program outcomes that are, after all, the underlying rationale for reform. Helping USAID field missions who are on the front lines of this process at the country level, engage productively, and at an early stage, in health reform is an important part of Global Health's responsibility in family planning and reproductive health as well as the other PHN program areas. The new FP/RH service delivery strategy must take into consideration this important contextual reality in almost every country where USAID is present and provide for technical and strategic leadership, both to assist field missions and in coordinating with other donors at the global level.

Health sector reform is a relatively young process. There is little hard evidence to date to demonstrate its successes. Many mistakes have been made in the process of learning what works. The complexity and difficulty of the process has also been seriously under-estimated by donors. Collecting data on health program changes resulting from reform is a very important area that needs more attention and one in which USAID could make a major contribution. In some countries, SWAps provide an opportunity for donors to coordinate their activities at the country level. They may, but do not necessarily, include pooled funding arrangements. The most important part of SWAps is the coordinated planning and monitoring process in which USAID can be an important partner even if it does not participate in pooled funding arrangements.

There are other areas where USAID missions can engage to ensure that the health reform process does not undermine FP/RH outcomes. The lack of adequate procurement capacity at the country level, for instance, has been one of the most difficult problems to overcome but it is an area where USAID has much to offer. The emphasis, however, needs to be on

developing and institutionalizing the host country's procurement system, thereby having one national system that all partners utilize. The mechanism for financial flow is another important area in the reform process. National health accounts help to understand funding flows but they tend to be too aggregate. More detail is needed to track expenditures for specialized areas such as family planning and reproductive health. USAID can make a significant contribution to the reform process by using tools such as the DHS (with the poverty quintile index) to map service utilization, track those who do and do not benefit from reform and determine whether the poor are being reached.

Decentralization, which often accompanies health reform, has fundamentally changed the way programs are introduced and scaled up, primarily because the initiative and funding may no longer come from the central MOH. The process has been most successful where there was considerable attention to capacity development. Community involvement and generating the demand for services at the client level are key issues in facilitating and strengthening decentralization. Decentralization and integration go together. Defining the essential service package (including FP/RH services) is a good organizing principle for decentralization. Building capacity for decentralized management of integrated programs is sometime complicated by USAID's funding categories.

USAID PHN officers and their implementing partners need technical information and training in the area of health reform to enable them to become full partners in the process. GH needs to find a way to convey technical information in ways that can be readily used by field personnel and support their efforts once they are at the table with other donors on health reform.

Addressing FP/RH Programs in HIV/AIDS Endemic Environments

In HIV/AIDS endemic environments, and even in low prevalence situations, FP/RH programs are affected by the impact that HIV/AIDS has on the service delivery system. In Africa, the shift of attention to HIV/AIDS – both staff time and political pressure – has minimized the focus on population and family planning. Missions say that they need more guidance on how to manage this situation.
It is critical to keep family planning on the agenda in countries where decision-makers are beginning to overlook family planning because of more pressing health problems such as HIV/AIDS. FP/RH services and HIV/AIDS prevention programs must be linked and must reinforce each other. For instance, in VCT and MTCT programs, family planning counseling and service delivery are essential, not only for programmatic but also ethical reasons. This is difficult in environments where the basic health care systems are overwhelmed by the cost and the direct human resource losses caused by HIV/AIDS. Huge increases in external funding for HIV/AIDS and the vertical funding streams through mechanisms such as the Global Fund also risk dwarfing and sidelining other essential health programs and diverting scarce human resources.

USAID can play an important role in assisting countries to use additional HIV/AIDS, TB and malaria resources to help protect or strengthen the basic health care system, draw in private providers and NGOs, and educate people directly about behavior changes

necessary to curb those diseases as well as improve their reproductive health practices in general.

GH has an important role to play in providing practical programmatic and technical guidance to Missions, sharing best practices, undertaking needed applied and operations research and representing USAID in global fora where these issues are being discussed. The field technical guidance to be issued this year on FP/HIV Integration is a good example of the kinds of guidance needed by the field missions. Such guidance must also be accompanied when requested by staff who can work with missions to help operationalize the guidance, given how stretched many field staff have become in recent years. Future FP/RH service delivery activities will need to include staff with expertise and recent field experience in this area given the magnitude of the problem, particularly in southern and eastern Africa.

Sustaining Programs

- **Private and Commercial Sectors**

The public sector is critical for reaching the poor, but in many countries, both poor and rich alike are heavy users of private sector services and rely on commercial outlets for contraceptive supplies as well as drugs. Private practitioners will become an increasingly important provider of FP/RH services over the next ten years and in many countries are seen as important partners in meeting national demand for services. They can help fill a resource gap that the public sector cannot meet on its own. Studies show that many clients can afford and indeed are willing to pay for health services. Public sector programs need to make sure that they are targeting unmet need among the poorest groups but are not destroying incentives for the private sector to serve those who can afford to pay. Government services have not been particularly good at targeting the poor and have often benefited higher income groups disproportionately. Contraceptive prevalence rates, as well as knowledge and attitudes about family planning, are all consistently lowest among the poorest population quintiles in most countries.[6] It is important that GH makes much greater efforts to think creatively and work more actively with private and commercial entities in the future. Expanding quality of care initiatives must involve private providers as well as government ones in order to reach the populations needing FP/RH services. Given that most population growth in the developing world will occur in urban areas, USAID will need to strengthen approaches that work well in urban settings. These approaches certainly include social marketing and other private sector strategies.

In recognition of these facts, a new Commercial and Private Sector strategy is currently under development in GH. While this is an important effort, private sector strategies also need to be part of other GH programs in FP/RH such as strengthening clinical services or training. Working closely with the Policy and PHRplus projects also provides a good way to understand the broader aspects of the organization and financing of services at the country level and ensuring that changes brought on by health reform support FP/RH outcomes.

[6] PHNI Project analysis of Family Planning by Wealth Quintile (DHS)

- **NGO/PVO Programs**

GH has also recognized the unique role that NGOs and US-PVOs play in FP/RH programs, including developing an "Action Plan" in July 2002 for future work with these organizations. As stated in this plan, PVOs and NGOs have unique skills in the development arena that are generally not found among other USAID partner organizations. PVOs and NGOs know how to organize and mobilize communities, reach into households to change behavior, work with socially or geographically marginalized groups and help empower those who would otherwise not be able to access modern health care, including FP/RH services. The SDI Division will be working with selected Missions beginning in FY 03 on a new PVO/NGO Initiative geared to developing and scaling up non-government programs in FP/RH. [7]

- **Contraceptive Security**

In their "Trends and Issues" paper, Ross and Stover state "The tremendous growth in the number of family planning users in the future will require changes in the way family planning services are offered. Growth in the absolute number of contraceptive users reflects results from growth in the percentage of couples using a method, compounded with growth in the number of couples. Both have been sharply upward since the mid-1960s, and a brief calculation suggests the implications for services, for contraceptive commodities, and for related personnel (principally in the public sector). From 1965 to 2000, a period of 35 years, the number of women in union in the developing world (including China) more than doubled, from 342 million to 813 million. There was also a rise in the percentage using a contraceptive method, from about 10% to about 60% now. Putting these two changes together yields the historic increase from only 34 million users to about 488 million. That gain reflects a revolution in reproductive behavior, and in the service institutions that have emerged to support it." (p 28)

They refer to the fact that in April 2001 in Istanbul, donors met to talk about "Meeting the Challenge: Securing Contraceptive Supplies," to draw the world's attention to an incipient crisis in contraceptive security. "As prevalence of use has risen, compounded with growing populations, the numbers of users needing contraceptives has grown rapidly… The UNFPA estimates that the amount required for contraceptives alone is US$572 million in 2000."(p16)

Expanding access to family planning is meaningless unless it is accompanied by the continued availability, either through public or private channels, of contraceptive supplies. Many missions are struggling with this issue, particularly where USAID has been a major supplier for government programs. Over the coming decade, missions will need help from GH to identify affordable alternative sources for financing contraceptive commodities as well as working with other major donors globally to find solutions. Making longer-term methods more readily available is also part of the solution. USAID's

[7] "Enhancing PVO and NGO Partnerships in Family Planning and Reproductive Health", Bureau for Global Health Action Plan, July 2002.

Contraceptive Security team has a number of activities already underway to look at issues such as analysis of lessons learned, looking at market segmentation issues to identify population groups needing subsidized supplies as well as those who can afford to pay, communications with other donors, advocacy and awareness building efforts related to contraceptive security and so on. These efforts are particularly important in light of health reform efforts, poverty reduction strategies and other changes that might have a profound effect on the availability of contraceptives. This is an area where a global partnership that includes substantial resources for the poorer countries is probably warranted.

III. Programmatic Support to the Field

The consultations with PHN Officers in the field missions also revealed important programmatic and management issues that must influence the SDI strategy as much as the technical ones. Field missions have very diverse needs ranging from the need for limited technical assistance in selected areas of their portfolios to complete reliance on central mechanisms for implementation of their programs. Needs change over time depending on circumstances within the countries. These include factors such as mission staffing, preferences of the host government or USAID mission leadership, funding levels, changing program requirements, and so on. In order to serve the field appropriately, SDI must design programs that are flexible, respond to a variety of different needs, but also that provide the technical depth and specialization in certain topics that field missions need to enhance their programs. These central mechanisms must also provide optimal support to field staff who are often very stretched from the managerial side. The substantial increase in technical staff in SDI bodes well for meeting the expressed needs from the field missions. The SDI staff can assist the field with both technical and management support. The following are key points generated from extensive consultations on field programmatic needs.

Scope of Central Projects

One consistent message from consulting with field PHN officers is that simplifying management is paramount. In general missions are understaffed and PHN staff, in particular, are seriously over-extended. Central projects that help ease their management burden while providing needed technical support are valued. Those that create new management burdens or result in a fragmentation of the Mission's portfolio are not attractive. Many Missions are choosing to develop bilateral projects and procurement mechanisms, which are directly responsible to the Mission, involve fewer global "hotel" costs, and provide a consolidated management unit for a broad range of activities. These missions may supplement their bilateral projects with use of technically specialized central projects for particular aspects of their program. Other Missions are choosing to run their programs largely through field support in order to avoid the complications of doing their own procurements and to lighten their management loads. A few Missions (such as India) have local restrictions on direct TA contracts that make use of central projects the only practical way of getting the specialized assistance they need to support their bilateral programs.

Feedback from field officers on the scope of central projects was varied depending on their own needs and circumstances. The Africa SOTA session indicated that some people felt that large, general projects that provided "one-stop shopping" were not desirable because their technical depth was limited. These officers wanted more specialized projects that could supplement their own bilateral programs in areas in which they needed special assistance, which could explain why Advance Africa is currently under utilized .

Other officers felt that broader, more comprehensive projects were important because the USAID/Washington mechanisms needed to be able to provide a variety of technical assistance to integrated programs under one umbrella CA without having to resort to having multiple CAs, each providing different kinds of expertise. The issue is sometimes related to the fact that a Mission has a productive working relationship with one or more of the CAs that they wish to continue and broaden into various other elements of their programs rather than seeking multiple partners.

Providing missions with affordable alternatives and better accountability.

Missions are clearly sensitive to the cost of central projects which are viewed as being more expensive than bilateral contracts or agreements because Missions have to pay for part of the "hotel costs" associated with keeping a stable of subject matter specialists available to respond to a variety of needs across many missions. One of the reasons that IQCs (like TASC) and Leader/Associate Contracts (like EHP) have become increasingly popular is because Missions have the ability to develop scopes of work for country specific activities and pay only for the task order involved without having to go through a lengthy procurement process of their own.

Mission PHN Officers also complained about the lack of prompt financial reporting on central projects, which sometimes compromises their ability to manage the financial aspects of their activities. Central Cooperative Agreements (in contrast to contracts) cannot be required to provide country-by-country financial or programmatic reporting. Doing so certainly adds to the cost and complexity of their program. Nevertheless, many CAs attempt to provide timely programmatic and financial reporting because they do understand why Missions need this information.

Improving the utilization of best practices and new research findings

There seems to be fairly universal consensus that USAID and its partners do a terrible job of disseminating important technical and programmatic information in ways that are cost-effective and useful for the field. Copious technical reports are generated by each project and sent to Missions world-wide in hopes that the research findings or best practices will find their way into new and on-going programs. Developing best practices, after all, is a pointless exercise unless they find their way into on-going development programs in the field. Valiant attempts have been made to summarize and otherwise make the volumes of information more user-friendly and practical. Unfortunately, most of these attempts have not succeeded in making this kind of information available in a form and at a time when the field officers need it for decision making. Again, over burdened mission staff do not

have the time to wade through long documents looking for the specific pieces of information they need at the right time.

A web-site providing state-of-the-art technical information and research across all PHN programmatic areas and indexed for easy access by field staff, might be a good first step. Some efforts on specific topics have been taken in this regard but they are so far limited in scope. Websites, however, are only a partial answer. They require frequent attention to updates and also to ensure that the highest quality materials are available on the site. GH could do much more to bring new technologies and program innovations to scale. This will require concerted efforts at inter-office collaboration within GH, something that has been traditionally difficult and a great deal more direct and frequent communication with the field.

Improving timely support and communications between missions and USAID/W

Missions that have the capability to enter into and manage bilateral population projects, and choose to do so, must have Agency resources to support their efforts in keeping with the Administrator's desire to see more responsibility and resources shifted to the field. GH needs to conceptualize new ways of providing technical support to field bilateral programs as well as providing appropriate mechanisms to program field support funds. This critical issue was emphasized by field officers during consultations on the SDI strategy. Field missions want GH to be supportive of their bilateral work. More attention is needed to determine the most effective mechanisms to support the field.

There is a tremendous desire on all sides for more frequent consultations among Missions and between Missions and Washington. A study in August of this year on the Use of Bilateral Mechanisms[8] pointed out that Washington operates in an information vacuum when it comes to bilateral PHN projects (other than the knowledge individuals have as a result of personal experience with the mission). Travel funds are limited and therefore Washington staff, especially seasoned direct hire staff who know the mission environments, cannot visit missions to assist very often. It is very difficult for Washington to provide timely and relevant help to field missions when there is so little information and limited contact. Senior staff in Washington are over-extended and are too seldom available to travel to missions to provide strategic and policy-related advice and yet, these are the very people who can and should have biggest influence on field programs. SOTA meetings, which are highly valued by both the field and Washington, are very infrequent and not a good substitute for more frequent communications. Some CTOs in Washington, it was noted, dislike doing the managerial tasks or financial management that is needed most by Missions and prefer to engage in more interesting technical work or travel.

At the ANE/E&E SOTA meeting, field staff suggested that more frequent sub-regional meetings (attended by Washington senior staff) would be very helpful and a cost-effective way of sharing best practices and discussing problems. A good model cited was the regional biannual meeting of the southern Africa PHN Officers.

[8] Thollaug, Mamlouk, "Use of Bilateral Mechanisms for PHN Programming in the Field" Aug 2002.

IV. Existing Portfolio

Current Portfolio: The current set of projects cover the full range of technical areas needed for enhancing FP/RH service delivery. Strengthening clinical FP/RH services and related pre and in-service training are provided by EngenderHealth and TRH/JHPIEGO. Improving the performance of frontline health workers including skills development, on-the-job training, and changing provider behavior are the main focus areas of PRIME II. The Management and Leadership (M&L) project aims to improve leadership and management skills as a way of ensuring the effectiveness and sustainability of services. The NGO Networks for Health, CARE/MORR and CEDPA-Enable activities will be ending soon. A new NGO/PVO Initiative to partner with selected missions on NGO/PVO programs will begin this fiscal year to utilize the special skills that those organizations bring to FP/RH programs. Advance Africa and Catalyst are FP/RH service delivery projects that are designed to respond to a broad variety of mission needs as well as develop best practices in improving access and quality of care. The Commercial Marketing Services (CMS) Project is coming to an end; as mentioned earlier, a new strategy and procurement for working with the private and commercial sectors is currently under design. Working with youth and adolescents is also an important priority for strengthening FP/RH services and an area needing the exploration of best practices given the sensitivity and difficulty in many countries of working with youth. The current YouthNet project, in collaboration with the HIV/AIDS Office, works on that issue.

This is a fairly comprehensive portfolio that does provide expertise in a wide-range of FP/RH service delivery expertise and a large variety of choices to the missions. The question is: how can on-going projects and new activities be shaped to have greater strategic impact? What value-added do they bring to mission programs and how can core resources to these activities be allocated in the most cost-effective way possible?

Utilization of Central Projects: Given the technical and programmatic needs identified by the wide range of stakeholders, it is important to look at the current portfolio to identify the nature of new activities needed. An analysis was conducted earlier this year, the purpose of which was to identify technical mandates of projects within the SDI Division; describe current activities; recognize overlap and duplication, if any; suggest options for management efficiencies and technical synergy; identify management and programmatic implications of suggested options. Some of the observations of this exercise are noted below.

- The analysis revealed that there were some areas of overlap among the major service delivery CAs with both positive and negative implications. Overlap in technical areas may even be beneficial as it can contribute to impact, more holistic programming, and a greater choice of CAs for missions. However, overlapping mandates may mean that CAs become competitive and behave in ways that detract from functioning as a team at the field level. For future procurements, it may be advisable to define a sharper technical focus and rely on competitive

procurement to award agreements or contracts whose mandates are clearly distinct.

- Most importantly, however, overlapping mandates raise serious questions about the efficient use of resources. Developing capacity in US institutions to provide specialized assistance to the developing world has been an important USAID contribution but it is expensive and must be weighed against the benefit of those resources being allocated directly to country programs. The cost of maintaining these major central projects is substantial and needs to be minimized to provide only (1) the support needed by field missions and (2) the technical innovation and leadership functions that are important GH mandates. This is a critical issue for future designs.

- Missions do want GH programs to be able to provide specialized technical assistance in areas that require innovation and leadership. A leader/associate mechanism might offer some advantages not available in the Cooperative Agreements and Contracts currently most widely used. Missions have responded well to a leader/associate type contracting mechanism, for instance, because it allows them to pay only for activities within their own countries but has the advantages of a centralized technical capacity and the ability to take field support funds in a task order managed by GH.

- For existing central projects that are highly under-subscribed from field support, it may be necessary to cut back on central staffing and administration to save on hotel costs and refocus activity on the countries that are interested and on core-funded activities that related to GH mandates.

Future Projects: The most important question to ask is: are new activities needed or can the same results be achieved by the strategic placement of core funds in existing mechanisms. Given that the EngenderHealth and JHPIEGO projects are coming to an end in September 2003, and given the priority for continued work in the areas of clinical family planning development and training, new activities in these areas may be needed. The evaluations of both projects have provided very useful guidance about adjustments needed in both the structure and the content of these kinds of projects. SDI will continue to have the responsibility to provide technical leadership in all dimensions of service delivery through centrally managed projects as well as to provide vehicles, when requested by field missions, for the implementation of bilateral programs.

There are also projects that may need to be amended, and their total size decreased to reflect lower than anticipated field support funding from field missions. It is important to avoid wasting scarce Agency resources on maintaining large technical staffs within projects that are not operating at the scale hoped for in the design process. A careful analysis needs to be performed to determine whether Advance Africa is appropriately staffed relative to the activity underway and whether the costs are in line with the anticipated outcomes.

V. Management and funding issues

Future Global Funding Issues

The Policy Project paper on Trends and Issues points out that a most compelling concern is the tremendous growth in the number of family planning users in the future that will require changes in the way family planning services are offered. Some have suggested that most organized family planning programs will almost certainly disappear by the middle of the century as programs become institutionalized within existing health systems.[9] But in the meantime, these programs have a critically important role to play and require huge resources, including continuing subsidization, especially of programs in the pre-transition countries. Donor funding for these programs is already declining and that decline is likely to continue. And yet the use of contraception will need to increase significantly and current acceptors need to be maintained and served. Clearly new strategies are needed to ensure that these growing needs are met in affordable and sustainable ways.

Resources should be made available by GH to support important global partnerships with other donors, foundations, field missions and international organizations in the area of FP/RH. Human resources, as well as financial ones, need to be devoted to ensuring that USAID is an important player in these multilateral efforts. These are efforts that cannot be supported on an individual country level. Field missions expressed a need for GH to provide more leadership in several areas of FP/RH. USAID, for instance, should be an important player in policy reform efforts that affect how health and family planning services are organized and financed. Joining multilateral efforts will help USAID have a bigger voice and ability to influence important international developments in the sector. Interviews with other donors and foundations suggested that USAID's voice on population issues is important and that more visible leadership would be welcomed.

Agency Resource and Management Issues

USAID operates on annual appropriations but generally works on projects and procurement mechanisms of five years. Funding for PHN programs come through four streams of money (Child Survival including maternal health, HIV/AIDS, Population and Infectious Disease.) Guidelines for proper use of each type of these allocations pose challenges for programming in a field environment where most services are integrated. The annual allocations of each category of money changes from year to year further complicating funding, especially for field missions who may not get the kind of money they need for the nature of their programs. Considering the political environment for the Agency, these constraints are unlikely to change dramatically in the near future, although the importance of building support for these programs in Congress has never been more important.

[9] Caldwell, Phillips, Barkat-e-Khuda, "The Future of Family Planning Programs", Studies in Family Planning, Volume 33, No. 1, March 2002.

Finding ways to reduce the management burden associated with USAID's complicated funding mechanisms is crucial, especially for field missions, many of which have suffered substantial staffing cut backs during the past decade. Management considerations are paramount in the choices Missions make about the mechanisms they will use to implement their programs. Missions may well forego the opportunity to draw on central projects, despite the expertise and additional funding they bring, if it means that they have to work with additional management units or find the field support funding system too cumbersome.

Mission OYBs currently account for 64 % of all PHN funding, with about half in field support and the rest in bilateral projects. The remaining 36% is programmed by GH largely for state-of-the-art, field-based activities and for support to international organizations. As noted earlier, currently little is known in USAID/W about the details of bilaterals, their successes or even their primary focus. Given the magnitude of PHN resources programs through bilateral projects, GH needs to better informed about them and be in a position to assist missions as needed in implementing these programs. For field missions, the ease of program management becomes an issue in selecting a funding mechanism. The Thollaug/Mamlouk report states that "…the reasons cited for choosing a centrally managed instrument over a bilateral approach or vice versa did not seem to be rooted mainly in technical considerations. …concerns about program manageability tend to overshadow the objective of applying the best technical solution to the health issue at hand." (p 20) Furthermore, the authors conclude that the "lack of systematic information about field based programming in GH is one manifestation of the current relationship between Washington and the field. The quality, quantity, and consistency of interaction are limited by inadequate staffing and excessive management burden both in missions and Washington. A greater emphasis on developing country-specific expertise among GH staff, plus strengthening the country team system, could make the field-GH connection more consistent, productive, and adaptive to the myriad realities faced in USAID's field missions." (p 21)

There are also staff management issues in USAID/Washington that are broader than just the SDI Division but affect the Division in terms of getting the most 'mileage' out of limited human resources. The bureaucratic culture in Washington encourages large numbers of staff to attend lengthy technical meetings and presentations that may be related only tangentially to their primary work objectives. Too many meetings are held simply to share information rather than make important decisions. There is not enough attention paid to limiting meeting participants to only those who must attend to achieve the stated objectives of the meeting, using other media for information dissemination and holding staff accountable for how they spend their time. Part of the problem may relate to a lack of clarity among staff about the mandate of central offices and insufficient guidance from supervisors on how staff should spend their time.

VI. Future Program Options

Strategic Choices

Given all of the information summarized in sections I – V, how can the SDI strategy best support the Office of Population and Reproductive Health in carrying out its strategic objective. GH itself needs to take a fresh look at its mandates and the vehicles it uses for working in global health in general. The "value-added" of central projects and the functions that distinguish them from bilateral programs, should guide the nature of the activities that are designed. These mandates clearly must include providing technically specialized assistance to the field, global leadership and research.

The recently revised Strategic Objective is to: advance and support voluntary FP/RH programs worldwide to reduce unintended pregnancy and foster improved RH practices. One of the most crucial roles for the GH Bureau to attain this objective is continuing advocacy for FP/RH programs. Other partners clearly want USAID to exercise this kind of global leadership in the population field. Some feel that renewed enthusiasm and greater support for population programs will require a new vision, which in simple but compelling language (perhaps tied to ethical and humanitarian concerns) helps people understand its global importance. There also needs to be a realignment of senior staff time on activities related to building global partnerships, working with other donors to address key global issues facing FP/RH programs and on global advocacy efforts.

Relative to other activities in the office and in its role with field missions, SDI itself must shape its mandate and programs to get the best value for the Agency as a whole within the available human and financial resources. Furthermore, it must monitor and evaluate the investments being made in order to determine whether they are making the intended contribution over time.

Various approaches to improving the impact of core human and financial resources were discussed at an SDI Strategy Team meeting on December 3, during which the following agreements were reached.

Priorities for Core Financial and Human Resources

While not a problem unique to SDI, the Division is having difficulty managing large projects, making judicious use of resources, and, at the same time, providing the strategic and technical support to field missions that is so badly needed and wanted. Competing priorities are diluting the opportunity to have a major impact. SDI's vision should include providing missions with the skills and supplementary resources needed to ensure that its FP/RH programs are scaled up to have significant impact as well as being as evidence-based and technically-sound as possible. This vision, would, over time, suggest that SDI manage fewer projects and make its technical staff more readily available to missions to support field activities. With the increase in SDI technical staff, it should be possible to meet the objective of making technical expertise more available to the field.

A related point is that, in order for core resources to make a difference, they cannot be sprinkled in small amounts across the entire USAID world. Difficult but necessary choices need to be made about selecting countries and programs where a substantial infusion of core money is likely to have a major impact by bringing programs to scale. Again, because not all countries require the same kind of assistance, some categorization of countries, may facilitate critical thinking about the use of resources.

At the December 3rd meeting, priorities for use of SDI's core financial resources were identified as (1) advocacy for, and adoption of, best practices for family planning and reproductive health service delivery in collaboration with field missions and with external partners and, (2) application of core resources to complement mission efforts to strengthen institutions and local capacity at the country level. The highest priority for use of SDI human resources was to provide the field missions with the technical expertise and strategic assistance they require to strengthen their FP/RH service delivery programs. If this priority for staff is to have meaning, performance evaluations and determining how staff spend their time must be measured by how well missions are served. In addition to these priorities, the management of current and future programs is a critical role for SDI staff. It is particularly important to reduce the management burden of the field Missions through programs that are focused and well-managed by SDI.

Prioritizing Countries

The model suggested by Ross and Stover, of categorizing countries into three groups: pre-transition countries, transition countries and low fertility countries, was thought to be useful in terms of prioritizing the **types of assistance** they may require rather than as a way of choosing countries with which to work. Geopolitical and other country selection factors would make anything else impractical. For instance, in pre-transition countries, SDI's assistance would be strengthening health systems geared to expanding access and quality of services particularly when utilization rates are very low. In transition countries, increasing method mix and helping find ways to scale up programs might be the focus. In low fertility countries, primary attention could be on policy and issues related to sustaining programs over the long run.

Other options for categorizing and prioritizing country work were discussed, particularly in relation to assisting field missions on strategy development. The concept of segmenting the population by wealth quintiles to identify those in greatest need, to appropriately target programs, as well as to identify those who can afford to pay for services or use private and commercial sources, is useful. As mentioned earlier in the paper, the poorest quintiles in all countries show the lowest utilization of family planning as well as most other health services, and are often paying a much greater proportion of their incomes for health care than the general population. This kind of market segmentation can help SDI and GH play an important role to test ways of targeting programs more effectively for reaching the poorest as well as finding ways of serving those who can afford to pay. This also enhances USAID's ability work in concert with other donors and host countries on specific poverty reduction strategies. As mentioned in

Section II, the DHS and other surveys can help USAID, and all of its partners, map service utilization and to track those who do and do not benefit.
Another potentially useful way of categorizing countries and assisting field missions is by looking at the health "systems" issues that affect service delivery. Given the profound impact that changes in the way health services are organized and financed are having on field programs, and because there is enormous variation in the challenges the programs face, field missions may need help in devising strategies to keep focused on outcomes and work constructively with the change process. Service delivery improvement is, after all, a systems strengthening effort. It is crucial that SDI is able to draw on specialized technical expertise resident in existing mechanisms such as PHRplus and Policy to provide the assistance the field requires, using SDI core resources and technical expertise within the Division.

Future Needs

Section II of this paper outlines areas that many of USAID's staff and stakeholders believe to be important topics for which GH needs to provide leadership, direction and support to the field. Few of these topics require the development of new projects. Many existing projects in others divisions and offices, as well as on-going projects in SDI, provide mechanisms through which these priorities should be addressed if core resources were allocated more strategically. Work on strengthening FP/RH programs within reformed/decentralized systems can be undertaken through both Policy and PHRplus. Advance Africa and Catalyst, working with the IMPACT project in the HIV/AIDS Office, can offer best practices for FP/RH service delivery in HIV/AIDS endemic environments. The SDI Division has recognized the importance to working with private and commercial entities on FP/RH services and commodities and is moving forward with a new strategy. The non-profit sector will be addressed through the new NGO/PVO Initiative. This paper suggests that new activities may be needed to strengthen clinical FP services and to take a new, more consolidated approach to strengthening human capacity development.

Taking advantage of existing mechanisms across the GH Bureau is an important strategy for reducing the number of projects and reducing costs. Furthermore developing large central projects with large hotel costs may not be a very cost-effective development investment at this juncture. GH needs to find better ways of providing direct technical support to field programs and strengthening Mission capacity to manage programs. Fewer, more focused projects might better to able to address the R&D, and technical innovation and leadership, functions in FP/RH. At the same time, these activities do need to have the capacity to take field support for missions who need that option or provide for Mission-managed task orders in a variety of related program areas to increase flexibility and usefulness of the projects to the missions. New procurement mechanisms such as leader/associate contracts and cooperative agreements offer flexible ways of supporting the field and providing specialized technical assistance. SDI should also consider whether the "bread and butter" FP/RH technical support available through activities such as Catalyst and Advance Africa might in the future be better offered through mechanisms

such as TASC that give missions a selection of pre-qualified firms with which to contract directly.

The following areas were identified during the December 3 meeting as important because they represent future needs that cannot be met through existing mechanisms.

Strengthening Clinical Family Planning Services: To re-invigorate clinical family planning and related services, a new procurement should be considered. The primary focus should be clinical family planning services because expertise in this area is not readily available through the existing mechanisms other than Engender and JHPIEGO, both of which are ending this fiscal year. Most national programs need assistance to ensure that the quality of the clinical services meets international standards and that all elements of a clinical program are in place. Particular attention must be given to the in-service training of providers and also to ensuring that informed choice and volunterism are assured. Clinical family planning services must be set within a system where all methods are provided at different levels of the system and where couples are given the information they require to make an informed choice. While the focus of the new activity should be clinical family planning, other related clinical services should also be included such as PAC, STI counseling and treatment, maternal health services, and HIV/AIDS services where appropriate. The establishment and training for clinical services requires a technical approach that has been established over decades of work by the Agency Optimal service for potential users will require a "contraceptive life" approach – providing the appropriate method for a client at each stage of her reproductive life.

Human Capacity Development/Training: Developing and institutionalizing human capacity at the country level is an area needing much more emphasis. Other donors have also recognized this need and recently have been giving it more attention. GH needs a mechanism whose mandate is to provide GH and field missions with strategic advice and technical assistance related to human capacity development in family planning, reproductive health, maternal and child health, HIV/AIDS and infectious disease. The human resources constraints related to improving worker performance such as personnel deployment, compensation, accreditation and so on are critical across all of the PHN areas and should be dealt with in a more strategic fashion than the current fragmented approach would allow. This is also an area where working with other donors would facilitate better impact of USAID's investments. Many of the institutions conducting pre-service training (medical, nursing, and midwifery schools) need and demand curriculum change in more than just family planning. At the peripheral level, workers are providing an integrated set of services, which also argues for a more comprehensive approach. Currently a large variety of CAs work on issues related to training and some elements of improving worker performance but without much coordination, strategic direction or focus from an organization with a broader view. Prime II, JHPIEGO, M&L and QAP all work on various elements of human capacity development which ultimately, might be streamlined under one overall approach. Because this would need to involve all offices of the Bureau in consultation with regional PHN staff, program development may take some time.

Mission-Support Needs

Supporting Missions for Strategic Planning/Performance Monitoring: USAID/Washington staff will never be able to provide all of the strategic and technical help that missions request which is the rationale for having mechanisms such as Synergy, MEDS and PopTech. Consultants are fielded on request but much depends on their availability at the time needed and they often are not well connected to the issues that the Agency feels are paramount. There is a need to have a stable core of technical experts to assist missions with strategy and program development who are independent of the firms that will eventually compete for the work. These experts need to be aware of the latest state-of-the-art information available and maintain working relationships with technical counterpart in the GH Bureau in order to be as connected as possible to the Agency's perspective on a particular topic. SDI staff need to work with these existing mechanisms more systematically to establish a core group of strategy support consultants who have country or regional expertise as well as technical credentials in the areas needed by the missions. When missions have difficulties funding such experts, SDI core resources should be used. Likewise, Missions often want help establishing their performance monitoring plans. On-going projects such as Measure, working with USAID and its partners, can play an important role in establishing the monitoring and evaluation framework, after which it can be maintained and used locally. Finally, the same mechanism should also be used to improve USAID/Washington's information about bilateral programs that does not involve any additional reporting or documentation burdens on field missions. SDI staff need to be able to identify service delivery technical and programmatic issues with mission programs and to be able to offer assistance and guidance when necessary.

Information management: For the most part, the service delivery challenges in the field are applying and scaling up known technologies and best practices rather than creating new ones. There is often too much emphasis on creating new technologies and strategies rather than optimizing the use of exiting ones. There is also fairly universal dissatisfaction with the current procedures for ensuring that the information generated from research and the development of best practices are mainstreamed or scaled up in country programs. As mentioned in Section III, substantial resources are spent on developing and distributing technical information that is not being used effectively because people do not have the information in digestible form at a time when they need it. Thousands of hard copies of documents are distributed in Washington and to field missions and dozens of project websites offer similar information but substantial re-thinking needs to occur about how to make this kind of information practical and useful for field mission staff.

There are several needs that are already well-recognized by the Bureau. (1) The volume of technical reports needs to be reduced and rationalized, (2) the technical information coming from several sources needs to be synthesized and packaged appropriately and (3) a process needs to be established to facilitate the state-of-the-art and best practices information being incorporated into field programs. One step to address the last issue has been taken. PHNI will be developing and managing the internal USAID PHN website to

provide (and update) this kind of information for use by field and Washington staff. Further work is necessary, however, to address all three issues raised above.

Performance Monitoring and Evaluation

Developing reasonable M&E plans for strategic objectives as broad as those in GH is always difficult. Substantial resources have been spent by central projects on trying to measure outcomes that may be beyond their manageable interests with disappointing results. There needs to be a realistic approach to determining the outcome indicators that these projects should be held accountable for, including an appropriate allocation of resources for measuring those outcomes. Once decisions are made on some of the issues, it is very important for SDI to have a good performance monitoring plan and to report on performance at least annually. This will enable senior staff to consider whether any adjustments are needed in the strategy. The performance monitoring plan will depend primarily on how SDI defines its mandate, both for supporting the field and for global leadership on service delivery issues. Indicators would then need to be developed that reflect the added value SDI brings to field programs as well as the specific achievements on broader global issues. Annually, the Office and SDI need to assess the resources (human and financial) devoted to achieving the specific benchmark indicators and make a judgment about whether the level of resources are in line with actual outcomes.

VII. Key Decisions and Follow-up Needed

- Share revised paper with GH senior staff and obtain agreement to move forward with the activities outlined.

- Commission an analysis of Advance Africa to determine whether any amendments are needed is size and staffing. A reassessment of the likelihood of large field support commitments for projects such as YouthNet might also suggest the need to keep it as a smaller, more focused effort.

- Move forward with new activity design for clinical family planning. Much useful information has been generated in the course of the knowledge sharing meetings, interviews, special analyses, focus groups and other preparatory work for this Paper that can be used by SDI to develop the authorization document and RFAs/RFPs for a new procurement. The design should be initiated as soon as possible in January.

- A "human capacity development" working group already exists and should be commissioned by GH leadership to move forward with planning for a Bureau-wide Human Capacity Development activity.